

Specialized Medical Equipment, Supplies and Assistive Technology

Definition: Specialized medical equipment, supplies and assistive technology includes devices, controls, or appliances, specified in the plan, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, repairs not covered by warranty, replacement of parts or equipment and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation. This service may include consultation and assessment to determine the specific needs related to the individual's disability for which specialized medical equipment, supplies and assistive technology will assist the individual to function more independently. Consultation and assessment cannot be used to determine the need for supplies.

Providers: Specialized Medical Equipment, Supplies and Assistive Technology must be provided by Vendors who are enrolled with SCDHHS as Durable Medical Equipment (DME) providers **or** by vendors who are contracted through the local DNS board to provide the service. Vendors who are contracted through the local DSN board can **only** provide Medical Equipment, Supplies or Consultation. They cannot provide diapers, underpads or PERS. If a vendor is enrolled with SCDHHS as a DME provider, they **cannot opt to board bill**.

Please note: Durable Medical Equipment (DME) is the name of a service available to all Medicaid recipients in South Carolina. It is not the name of an MR/RD Waiver service.

Arranging for the Service: Once the recipient's need has been identified and documented in the plan, and it is determined that the provision of equipment or supplies will meet or address the need, you must determine if the needed equipment or supplies are available through the State Plan. The State Plan includes the service Durable Medical Equipment (DME) which is available to all Medicaid recipients and covers equipment or supplies ordered by a physician. **DME covers such equipment and supplies as hospital beds, wheelchairs, shower chairs, back and leg braces, crutches, oxygen, bandages, etc.** Furthermore, **liquid nutrition** (e.g. Ensure, Pedisure, Sustical, etc.) is covered by the State Plan as Durable Medical Equipment when the supplement is the recipient's sole source of nutrition. If the recipient has a "feeding tube" (i.e. G-Tube, J-tube, PEG tube, etc.) the supplements can be provided as Durable Medical Equipment and funded by the State Plan. The recipient must have a physician's prescription for the product and must have current Medicaid eligibility to obtain. You must include the provision of the supplements in the recipient's plan, but since this is funded by the State Plan, it does not need to be included on the Waiver Tracking System.

To determine if an item is covered by the State Plan, you can:

1. **Ask the provider for the appropriate procedure code for the equipment or supply requested and compare it to the equipment and supply list included in the Medicaid Provider Manual for Durable Medical Equipment which is published by SCDHHS at www.dhhs.state.sc.us. Click on "Provider Manuals" in the center of page and scroll down to "Durable Medical Equipment". Equipment and supply lists are under "Procedure Codes" in Section 4 of the manual;**

Please note: Items with ** require the providers to first submit a Prior Authorization to determine whether an item is covered.

(Then if there are still some questions)

2. Contact the DME representative at SCDHHS who serves your county;

You must document your attempts to determine if the needed items are covered by the State Plan. For some equipment or supplies, SCDDHS places limits on the frequency or amount of an item a recipient may receive. For example, up to 4 urinary leg bags can be provided during a calendar month. **If the recipient needs more than is allowed, a provider can submit the appropriate SCDHHS Certificate of Medical Necessity (CMN) Form to a licensed physician to note the amount needed and justification. The provider then submits a claim with the CMN for review.** If authorized by SCDHHS, the equipment or supplies can be provided in the amount needed and funded by the State Plan. **Only if it is determined that the needed equipment or supply is not covered by the State Plan may the MR/RD Waiver fund the service, Specialized Medical Equipment, Supplies and/or Assistive Technology.**

In most instances, Specialized Medicaid Equipment, Supplies and Assistive Technology is provided by a vendor enrolled with SCDHHS as a DME provider. However, there may be circumstances when a consumer's needs can be met by a vendor that is not enrolled with SCDHHS as a DME provider. We can allow vendors who are **not** enrolled with SCDHHS as DME providers to contract with the local DSN Board to provide Medical Equipment, Supplies and Consultation ONLY. This option would be used for items such as **liquid nutrition**, special diets (gluten free products), and lifts systems (e.g. Surehand Lift Systems). This option should lead to reduced cost. This option is not available for items such as diapers, pull-ups, wipes, etc.

For any single piece of equipment or supply which costs **less than \$1,500**, no bids are required. However, you must offer the recipient/legal guardian the choice of provider. You must document this offering of choice. The Service Coordinator or Early Interventionist cannot make the choice for the recipient.

For any single piece of equipment or supply which costs **more than \$1,500**, you must offer the recipient/legal guardian the choice of providers and assist with soliciting quotes from three (3) providers. These quotes may be verbal but must be documented in the record and included as a comment to the budget on the Waiver Tracking System (BDCOM). **NOTE:** For any single piece of equipment or supply costing more than \$5,000, three (3) written quotes must be obtained and submitted to Cost Analysis Division of SCDDSN via fax at (803) 898-9657 when the request is added to the Waiver Tracking System.

Once the provider is chosen by the recipient or selected as the "lowest bidder", and the budget information and comments have been entered in the Waiver Tracking System (S21) and approved, the service can be authorized. For providers enrolled with SCDHHS as DME providers, services are authorized by sending the **Authorization for Services (MR/RD Form A-5)** to the chosen provider. For providers that are contracted with the local DSN Board to provide Medical Supplies and Medical Equipment only, Medical Equipment and Medical Supplies services are authorized by sending the **Authorization for Services (MR/RD Form A-33)** to the chosen provider. In this instance, a copy of

the **Authorization for Service (MR/RD Form A-33)** must be sent to the DSN board's Director of Finance and the SURB Division SCDDSN Central Office.

1. **Medical Supplies** are those non-durable supplies that are not available through the State Plan and are of direct medical or remedial benefit to the recipient. This may include items such as **liquid nutrition** (when not the sole source of nutrition) and wipes, but will not include items such as soap, deodorant, shampoo, tissues, toilet tissue, etc., unless clearly linked to a direct medical or remedial need in the plan.

Please note: Wipes are available to those who are incontinent of bowel and/or bladder and are at least three (3) years old.

2. **Medical Equipment** is any durable or non-durable equipment item that is not covered by the State Plan and is of direct medical or remedial benefit to the recipient. This includes items that are "assistive" in nature such as large button telephones, strobe light fire alarms, flashing light alarm clocks, or any other items that are clearly linked to a direct medical or remedial need in the plan.
3. **Personal Emergency Response System (PERS)** is an electronic device which enables the recipient to secure help in the event of an emergency. The recipient may wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center, that is staffed by trained professionals, once a "help" button is activated. PERS services are limited to those individuals who live alone, or who are alone for most of the day, and have no regular caretaker for extended periods of time, and who would otherwise require extensive routine supervision. The rate for this service is set to \$36.00 for installation and \$36.00 per month for monitoring. Please use these amounts when entering budget requests onto the Waiver Tracking System.

The **installation of a PERS** is a one-time authorization and should be accompanied by an authorization for monthly monitoring. PERS are not covered by the State Plan.

4. **Diapers** are not covered by the State Plan, but are available through the MR/RD Waiver to those who are incontinent of bowel and/or bladder and are at least three (3) years old. The cost of diapers are restricted by the pricing guidelines set by SCDHHS. These guidelines limit the provision of diapers to a maximum of three (3) cases per month per recipient and requires that each case contain at least 72 size large diapers or 96 size medium or small diapers. The cost per case of small or medium size diapers will be \$70.08. The cost for a case of large or extra large should be no more than \$69.84. (see MR/RD rate table for more information).
- If an individual needs a particular diaper that exceeds the cost per case rule and the need for the diapers is **Medically Necessary**, then the **SCDHHS Department of DME Certificate of Medical Necessity Form** can be used. **When the Service Coordinator/Early Interventionist identifies the need for a specific diaper, he/she contacts a provider. The provider then initiates the appropriate Certificate of Medical Necessity Form by filling out the top portion of page one and all of page two, then, forwards it to the individual's physician to complete the bottom portion to include medical justification and signature of approval. This form must be completed every 12 months. The provider then sends the original CMN to the Service Coordinator/Early Interventionist who would then completes the Authorization for Services (MR/RD Form A-5) Form and forwards that along with a copy of the CMN back to the provider.** Given the exception to policy, diapers in this situation would be authorized under Medical Supplies (X1915) and **not** Diapers.

- If an individual needs more than the equivalent of 3 cases of diapers per month and the need for more diapers is **Medically Necessary**, then the **SCDHHS Department of DME Certificate of Medical Necessity Form** can be used. The maximum allowable is 5 cases and DDSN District Office approval is required. When the Service Coordinator/Early Interventionist identifies the need for more than 3 cases per month of diapers, the Service Coordinator should contact the provider and request a **Certificate of Medical Necessity Form** be completed. The provider will complete the top portion of the form and it will be sent to the physician. The physician will complete his portion of the form and send it back to the provider. The provider is responsible for getting a copy of this form the SC. This form must be completed every 12 months, as long as the need continues. The Service Coordinator/Early Interventionist would then be responsible for forwarding the completed **Medical Necessity Form** to the appropriate District MR/RD Waiver Coordinator when seeking approval. Once approval is obtained the **Medical Necessity Form** must be forwarded to the provider along with the **Authorization for Services (MR/RD Form A-5)**. Given the exception to policy, diapers in this situation would be authorized under Medicaid Supplies (X1915) and not Diapers.

5. **Underpads** are not covered by the State Plan and the costs are also restricted by pricing guidelines set by SCDHHS. These guidelines limit the provision of underpads to a maximum of three (3) cases per month. A case of underpads is defined as at least 200 22"x33" underpads or at least 150 22"x35" underpads. Each case of underpads can cost no more than \$43.65.
6. **Consultation** is not covered by the State Plan. Consultation can be used to assess and determine the specific needs related to the individual's disability for which specialized medical equipment, supplies and assistive technology will assist the individual to function more independently **prior to** the individual receiving the service. Consultation and assessment **cannot** be used to determine the need for supplies only. Assistive Technology Assessments/Consultations must be provided by Medicaid enrolled Occupational or Physical Therapists, Medicaid enrolled Rehabilitation Engineering Technologists, Assistive Technology Practitioners and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North American (RESNA), Medicaid enrolled Environmental Access/Consultants/contractors certified by Professional Resource in Management (PRIME) or by vendors who are contracted through the DSN Board to provide the service. A Consultation may be authorized by completing the **Authorization for Services (MR/RD Form A-33)**. The maximum amount allowed for a Consultation is \$300.00.
7. **Rental:** In certain circumstances, needs for equipment or supplies may be time limited (i.e. an individual is recovering from surgery and will need a bedside commode for 3 months). The definition for time limited rental services is when a particular item is not needed for longer than 3 months. In these circumstances, you should encourage the recipient to rent the needed item from their choice of providers. You must initially verify that the rental costs cannot be covered by the State Plan. If the State Plan does not cover the rental for the particular piece of equipment needed, then the cost of this rental can be funded through Specialized Medical Equipment, Supplies and Assistive Technology. This service would be authorized under Medical Equipment (X1916).
8. **Repairs** not covered by warranty and replacement of parts may be funded through Specialized Equipment, Supplies and Assistive Technology. Repairs and/or replacements of equipment may not be granted if it is determined that there has been abuse or neglect of the equipment or if the same repair has been done on the same piece of equipment more than twice in one year.

Consideration for further repairs would require documentation showing extenuating circumstances. . The SC should use his/her best professional judgment when determining if abuse/misuse of supply has occurred. This service would be authorized under Medical Equipment (X1916)

For each category of Assistive Technology items, the “Start Date” must be noted. The “Start Date” is the earliest date from which the provider can bill and receive payment for services. Along with the Start Date, the name of the item being authorized, the cost or dollar amount authorized and the frequency must be noted. The “frequency” indicates how often the provider can provide the item at the cost noted. For example, if the authorization shows “Item: 1 case Ensure Cost: \$34.50 Frequency: Monthly”, then the authorization allows the provider to provide 1 case of Ensure for \$34.50 every month until a new authorization for Ensure is sent or until a **Notice of Termination of Service (MR/RD Form 16-B)** is sent to the provider. Another example would be if the authorization shows “Item: BellSouth Model TX200 Telephone Cost: \$31.50 Frequency: “one time”, then the provider can provide one phone for \$31.50.

Back dating of referrals is prohibited.

Please note: When sending a new service authorization to a provider, you nullify any previous authorization to that provider. This does not mean that an authorization for a one-time item provided two months ago is nullified. It means if you have an authorization for ongoing monthly supplies with that provider and you send a new referral you must include those monthly supplies that continue to be needed.

Monitoring the Services: You must monitor the effectiveness, frequency, duration, benefits, and usefulness of the service along with the recipient’s/family’s satisfaction with the service. Information gathered during monitoring may lead to a change in the service, such as an increase/decrease in units authorized, change of provider, change to a more appropriate service, etc. The following criteria should be followed when monitoring Specialized Medical Equipment, Supplies, and Assistive Technology.

- One time items: within two weeks of receipt of item
- Ongoing services: at least monthly for the first two months and then at least quarterly thereafter
- Start over with each new provider
- Any single item costing more than \$1,500.00 requires an on-site monitorship within two weeks of receipt

One-Time Items

- Did the individual receive the item?
- What is the benefit of the item to the individual?
- Is the item being used as prescribed?
- Was the individual satisfied with the provider of the item?
- Was the provider responsive to the individual’s needs?

On-going items

- Has the individual’s health status changed since your last monitorship? If so, do all authorized supplies continue to be needed at the current rate?
- Are the amounts appropriate or do they need to be changed?
- Are the specific brands appropriate to meet the individual’s needs or does a change need to be made?
- Are additional supplies needed at this time? Are there any new needs?

- Does the individual receive his/her monthly supplies in a timely manner?
- Is he/she satisfied with the provider of the service?
- What are the supplies used for?
- Are the items being used as prescribed?

Personal Emergency Response System (PERS)

- At least monthly for the first two months
- At least quarterly thereafter
- Start over with each new provider

Monitorship of this service may occur with the individual/family or the provider of service. Some items to consider during monitorship include:

- Has the individual used the PERS since your last contact? If so, what was the response from the PERS provider?
- Does the individual continue to be left alone at home for significant periods of time?
- Is the individual satisfied with the PERS provider?
- Is the provider receptive to the needs of the individual?
- Does the service need to continue?

Reduction, Suspension, or Termination of Services: If services are to be reduced, suspended, or terminated, a written notice must be forwarded to the consumer or his/her legal guardian including the details regarding the change(s) in service, allowance for appeal, and a ten (10) calendar day waiting period before proceeding with the reduction, suspension, or termination of the waiver service(s). The general termination form that has been used in the past for all waiver services is no longer used. See *Chapter 9* for specific details and procedures regarding written notification and the appeals process.

TO: _____

RE: _____

Date of Birth

Medicaid # / / / / / / / / / /

☐ Medicare

Prior Authorization # / / / / / / / /

_____ Medical Supplies (X1915) Start Date: _____

Item: _____ Cost: _____ Frequency: _____

Item: _____ Cost: _____ Frequency: _____

Medical Equipment (X1916) Start Date: _____

Item: _____ Cost: _____ Frequency: _____

Item: _____ Cost: _____ Frequency: _____

Personal Emergency Response System

Installation (S5160) Start Date: _____

Monitoring (S5161) Start Date: _____

Diapers _____ x _____ = _____

# of diapers in case	# of cases	total # of diapers needed
1	1	1
2	1	2
3	1	3
4	1	4
5	1	5
6	1	6
7	1	7
8	1	8
9	1	9
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11	1	11
12	1	12
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129	1	129
130	1	130
131	1	131
132	1	132
133	1	133

Small/Medium 96 diapers = 1 case; Large 72 diapers = 1 case; X-Large 54 diapers = 1 case; maximum 3 cases

Frequency: ☐ Monthly ☐ Quarterly ☐ Bi-Monthly ☐ Bi-Annually

Size: ☐ Adult Small (T4521) ☐ Adult Medium (T4522) ☐ Adult Large (T4523)

☐ Adult X-Large (T4524) ☐ Child Small/Medium (T4529) ☐ Child Large (T4530)

☐ Youth (T4533) Start Date: _____

Underpads (A4554) Start Date: _____

Amount: ☐ 1 case ☐ 2 cases ☐ 3 cases Frequency: _____

Service Coordinator/Early Interventionist: _____ Name / Address / Phone # (Please Print): _____

Signature of Person Authorizing Services _____ Date _____

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

MR/RD WAIVER

AUTHORIZATION FOR SERVICES

BILLED TO DSN BOARD

TO: _____

RE: _____

Recipient's Name

/

Date of Birth

Address

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

SPECIALIZED MEDICAL EQUIPMENT, SUPPLIES AND ASSISTIVE TECHNOLOGY:

_____ Medical Supplies (X1915) Start Date: _____
Item: _____ Cost: _____ Frequency: _____
Item: _____ Cost: _____ Frequency: _____
Item: _____ Cost: _____ Frequency: _____
Item: _____ Cost: _____ Frequency: _____

_____ Medical Equipment (X1916) Start Date: _____
Item: _____ Cost: _____ Frequency: _____
Item: _____ Cost: _____ Frequency: _____
Item: _____ Cost: _____ Frequency: _____
Item: _____ Cost: _____ Frequency: _____

_____ Consultation \$ _____ (not to exceed \$300.00)

Service Coordinator/Early Interventionist: Name / Address / Phone # (Please Print):

Signature of Person Authorizing Services

Date

Copies to: SURB Division SCDDSN Central Office and DSN Board Director of Finance

**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM
FOR EQUIPMENT/SUPPLIES**

CERTIFICATE TYPE / DATE: INITIAL _ / _ / _ REVISED _ / _ / _ RECERTIFICATION _ / _ / _

SECTION A: TO BE COMPLETED BY PROVIDER:

- (1) Recipient's name: _____ Height: _____ Weight: _____
- (2) Recipient's Medicaid # (10 digits): _____ Sex: _____ DOB: _____
- (3) Date of (telephone/written/fax) order: _____ Date of service: _____
- (4) Provider's name _____ Provider's DME #: _____
- (5) Provider's signature: _____ Date: _____
- (6) Street address: _____ City: _____
- (7) State: _____ Zip: _____ Local telephone #: _____
- (8) Diagnosis codes (ICD-9): _____ (Descriptions): _____

- (9) Print treating/ordering physician's name: _____ License # _____
- (10) **SPECIALLY LIST ALL PROCEDURE CODES THAT ARE ORDERED BY THE TREATING/ORDERING PHYSICIAN FOR EQUIPMENT ON THE BACK OF THIS FORM**

NOTE: ALL PROCEDURE CODES THAT ARE COVERED, BUT DO NOT HAVE AN ESTABLISH PRICE, MUST INCLUDE MANUFACTURER PRICE LIST. RECERTIFICATION IS REQUIRED PRIOR TO EXPIRATION OF THE CURRENT CMN/AF FOR RETINAL ITEM(S).

SECTION B: TO BE COMPLETED BY TREATING/ORDERING PHYSICIAN ONLY:

(11) Indicate patient's ambulatory status while performing activities of daily living: __ No, Non-ambulatory __ Yes, without assistance __ Yes, with the aid of a walker or cane.

Is the patient susceptible to or have decubitus ulcers? __ Yes __ No. If yes circle stage(s): I, II, III, or IV.

Can the patient safely and effectively use the equipment ordered? __ Yes __ No. If no, please explain: _____

State the recipient's expected prognosis as it relates to the equipment/supplies prescribed: _____

Oxygen levels: SaO2 _____ PaO2 _____

Is additional information attached on separate sheet? __ Yes __ No (If "yes", enter recipient's name & I.D. Medicaid number on attached)

(12) Date last seen or evaluated by treating/ordering physician: _____

(13) Duration of need (maximum of 12 months): _____
(If duration is less than 12 months, please indicate)

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission or concealment of material fact may subject me to civil or criminal liability.

(14) **PHYSICIAN'S SIGNATURE** _____ **DATE** _ / _ / _ **(SIGNATURE AND DATES STAMPS ARE NOT ACCEPTABLE)**

**PLEASE REFER TO THE MEDICAID CMN POLICY IN SECTION 21 IN THE DME MEDICAID PROVIDER MANUAL.
(DME 001 – Dated 01/05/05)**

INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY

SECTION A:

LINES 1 THRU 10 TO BE COMPLETED BY ENROLLED DME
 TREATING/ORDERING
 PROVIDER:

Line 1 – Enter recipient’s full name, height and weight.
necessity.

Line 2 – Enter recipient’s Medicaid 10-digit number, sex and date of birth.

Line 3 – Enter the date of telephone/written/fax order and date of service.

Line 4 – Print provider’s name and provider’s DME number.

Line 5 – Provider’s signature and date.

Line 6 – Enter provider’s street address and city.

Line 7 – Enter provider’s state, zip code and local telephone number.

Line 8 – Enter diagnosis code(s) and description.

Line 9 – Print treating/ordering physician’s name and enter License Number.

Line 10 – List all procedure codes for Equipment/Supplies.

SECTION B:

LINE 11 THRU 14 TO BE COMPLETED BY
PHYSICIAN

Line 11 – This medical information is used to determine medical
(If applicable, enter the appropriate oxygen/saturation levels)
Line 12 – Date last seen or evaluated by treating/ordering physician.
Line 13 – Enter duration of need.
Line 14 – Physician must sign and date the MCMN.

Please list all procedure codes that will be utilized on the following lines:

Handwritten text on lined paper, likely a signature or name, written in cursive script. The text is partially obscured by a large, faint, diagonal watermark reading "amr".